South Dakota State Board of Pharmacy

4305 S. Louise Ave., Suite 104
Sioux Falls, SD 57106

COMPLAINT FORM

Name of Person Submitting This Complaint: _____

Mailing Address: _____

City, State, ZIP _____

Phone Number: _____ Email Address: _____

Name of Pharmacy or Pharmacist About Whom You Are Complaining:

_____

Address of Pharmacy:

_____

_____

Name of Patient Involved:

_____

Date of the Incident:

_____

I hereby declare that all of the information I have provided with this form is true and correct.

_____ _____

Signature of Person Submitting This Complaint Today's Date

STATEMENT OF COMPLAINT: On the back of this page or on a separate sheet type or neatly print your complaint. It is important to be as specific as is reasonably possible. Attach additional pages if necessary. Make copies and attach any documents (such as labels or prescription containers) which will support your allegation(s). After completing your statement of complaint, please sign and date the document. *The Board does not have jurisdiction over complaints involving pricing or billing disputes.*